



BC Coroners Service Child Death Review Overview

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History of Child Death Review

Unintentional injuries account for the majority of deaths to children and young adults in British Columbia. The largest portion of these deaths is attributed to motor vehicle incidents, falls and drowning. This trend is generally consistent across North America with respect to motor vehicle incidents and drowning. While many of these deaths appear to be accidental or unintentional in nature, there are usually a myriad of factors involved that lead to death. While statistics are able to tell us the number of children losing their lives each year, they are unable to provide answers on how to reduce or prevent these injury-related deaths. To look at it another way, statistics provide the who, what and where on how children die. Child death review on the other hand, provides the how and why of child deaths and contributes to strategies on reducing fatalities.

To better understand how children die, child death review teams were first started in California around 1978. This effort was the result of concern on the part of parents, health care workers and other professionals over the increasing number of children who were dying from abuse, neglect or injury from apparently preventable deaths. Since then, child death review teams have been formed in all states and have proven so valuable in ensuring deaths are understood that their use has spread to Canada and elsewhere. In the early 1990s the first of such teams was created in Canada. Part 4 will focus on what each of the provinces in Canada is doing.

Introduction

The core focus of Child Death Review in British Columbia is *prevention*, while promoting the health, well-being and safety of all British Columbian children. The process by which Child Death Review is conducted in BC is the primary focus of the first half of this report. In Part 1, titled *Child Death Review: A New Responsibility for the Coroners Service*, the evolution of the investigation of child deaths in this province is described, followed by an overview of the current process of conducting Child Death Reviews in BC (Part 2). In the section *What the Other Provinces Are Doing*, a brief overview of the Child Death Review process in some of the nation's provinces and territories is included in order to provide a background against which the operation of the process in British Columbia may be compared. Part 3 provides an overview of the prevention process and examples of recommendations made with respect to child deaths.

Part 1 – Child Death Review: A New Responsibility for the Coroners Service

The Children's Commission, which was created in September of 1996, was originally the agency charged with the duty of reviewing child deaths in British Columbia. Generally, this agency's review involved the use of a multidisciplinary committee, the creation and maintenance of a database on child deaths, and the publication of an annual report and occasional special reports regarding a variety of issues pertaining to child deaths.

In February of 2002, following the recommendation of the Attorney General, the Children's Commission and the Office of the Child, Youth and Family Advocate were eliminated, and an Office for Children and Youth was established to absorb a number of key functions, including the monitoring of services provided for children, advocacy, the investigation of complaints, education, and providing advice to the government on children and youth issues. On January 1st, 2003, the BC Coroners Service assumed the responsibilities related to Child Death Review. While we have always had the mandated responsibility of investigating *all* sudden, unnatural and unexpected deaths, including those of children, these changes resulted in the expansion of the Coroners Service's responsibilities to include three new areas of responsibility:

- the tracking of child deaths, including a public reporting component;
- the establishment and maintenance of a Child Death Review Team; and
- the maintenance of a database for all child deaths.

The latter responsibility follows from one of the goals of 2003/2004 set by the Coroners Service: the development of a new database in order to support the need for detailed research and analysis. This is crucial in order to improve our ability to identify and monitor trends through conducting subject-specific studies, to provide evidence-based recommendations, and is ultimately a particularly critical component to the development of an effective review process.

Part 2 – How Do We Conduct Child Death Review?

Descriptive Overview

The primary focus of the Child Death Review process in British Columbia is prevention, in addition to the promotion of the health, well-being and safety of children in BC. This is accomplished in the following steps:

Step 1- The Initiation Phase

The Coroner, Child Death Review initiates the review process by completing reviews of all sudden, unexpected and unnatural deaths and by developing and implementing investigative protocols. These efforts are made to identify trends or issues, and to ensure the effectiveness of child death investigations.

Step 2 – The Review Phase

Those trends and issues, as well as the circumstances of specific individual deaths, for which further review is deemed to be beneficial, are then examined by the Child Death Review Team. This team is comprised of senior managers within the Coroners Service and includes the Deputy Chief Coroner, the Assistant Deputy Chief Coroner, the Manager of Policy and Research, the Coroner, Child Death Review, and the Coroner, Medical Review. Specific attention by the team is given to the deaths of all those children who were in care of or receiving services under the *Child, Family and Community Services Act* at the time of their death or in the year preceding their death.

When the core team identifies issues which would benefit from review by other professionals, ad hoc representatives from a variety of other agencies will also be invited to participate in the process as a Multidisciplinary Child Death Review Committee. The involvement of ad hoc members depends on the following factors: their knowledge, skill or expertise in the specific topic area under review by the team; their commitment to the health, safety and well-being of children and youth in BC; and their ability to communicate or aid in implementing specific preventative strategies derived from the review process.

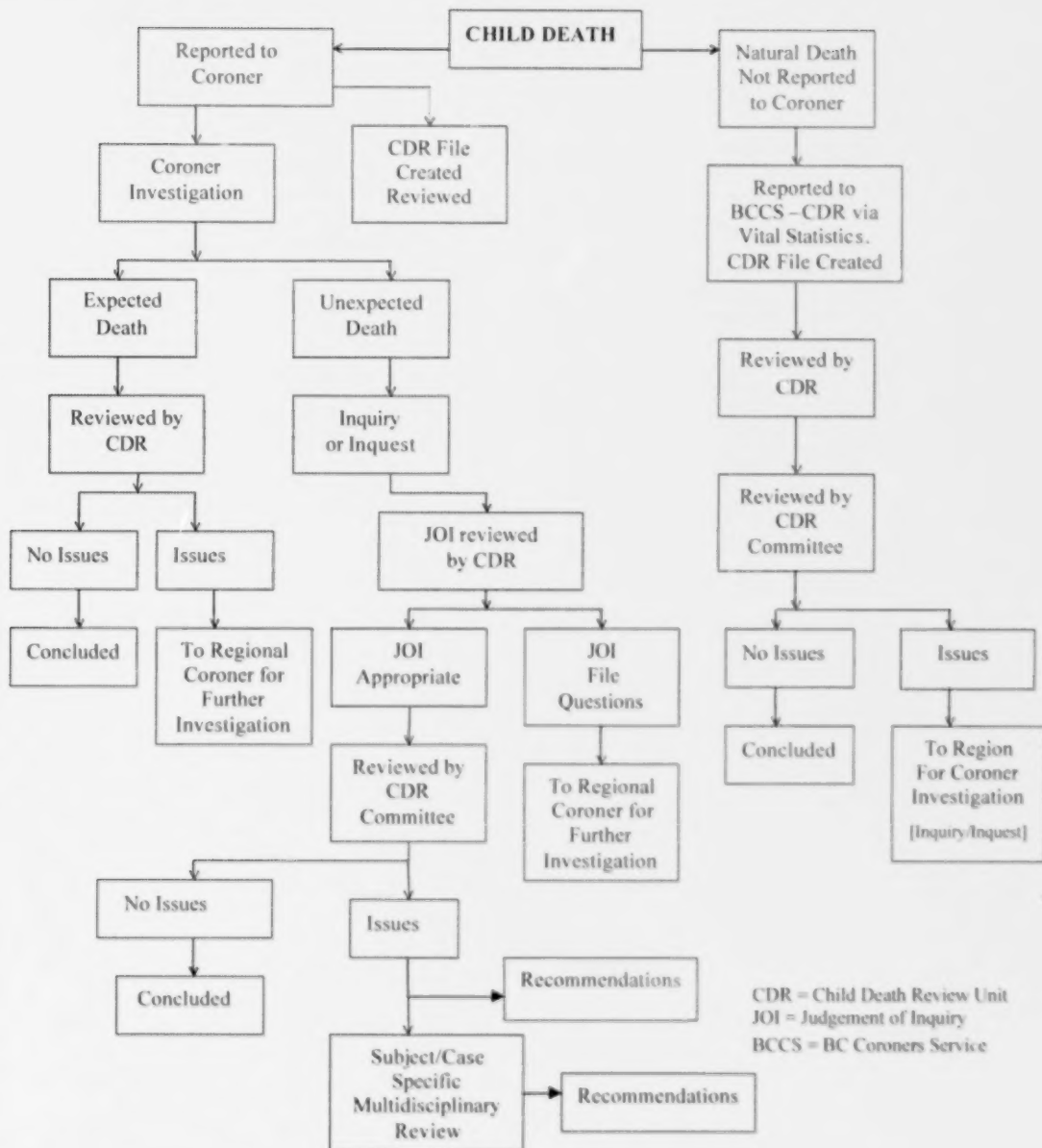
In addition to engaging in subject-specific examinations, and on occasion the review of individual child death cases, the Child Death Review Unit is responsible for maintaining a database on all factors relating to child death and helping in informing professionals from the relevant agencies as well as the general public of risk factors contributing to child deaths.

Step 3 – The Recommendation Phase

In the final stage, the Child Death Review process provides advice/preventative recommendations to the Chief Coroner on any subject related to child death. The Chief Coroner in turn addresses the issue with the relevant agency. The responses to these recommendations are monitored and recorded. The response rate is high, and the responses are generally quite positive.

Overall, the Child Death Review process is designed to supplement the work of investigating Coroners without limiting the Coroners' impartial, independent inquiries.

BC CORONERS SERVICE
CHILD DEATH REVIEW PROCESS



Child Death Review Committee Meeting - An example of Subject-Specific Review

While the Child Death Review process, as described above, is a relatively new responsibility of the Coroners Service, we have had the opportunity to hold a committee meeting that included the core members from the BC Coroners Service as well as members of other agencies affected by the topic of motor vehicle collisions. This meeting began with an overview of the statistics. We also discussed what has been done by the various agencies in preventing child fatalities in motor vehicle collisions.

It was highlighted at this meeting that there is an apparent need for improved data collection by all agencies, including the BC Coroners Service. This is something that this agency is aware of and is currently working on by developing a database. The design of this new database will help Coroners in appropriately and accurately collecting all of the necessary fields of data for each and every case. Data collection is very important and we realize that it must be improved in order to be able to conduct valid and reliable research. The analysis of this data to determine specific issues/trends was also emphasized as a crucial need, a task which is now possible due to the recent additions of the Data Analyst/Statistician and the Research Officer to the Child Death Review Team.

Finally, it was emphasized at this meeting that there is a need to ensure that the various key stakeholders with respect to motor vehicle collisions and fatalities are working together in a unified framework to ensure that the duplication of efforts across agencies does not occur. Certainly, the sharing of data and data collection tools, as well as analytical reports, is central to the development of this framework.

Part 3 – How Do We Help Prevent Deaths?

As mentioned at the outset of the previous section, the core focus of the Child Death Review process in British Columbia is prevention. The recommendations made are key in helping to improve public safety and prevent death in similar circumstances. Coroners can also make recommendations on individual cases. While the Coroners Service has no statutory authority to order change or to ensure that its recommendations will be carried out, it is generally successful in having most of its recommendations considered and acted upon. For example, a review of recommendations with respect to the child death cases in 2002 for which recommendations were made *and* a response was requested (i.e. 8 of the 12 recommendation cases); the service had an 88% response rate, with all of these responses being positive.

Below is a breakdown of the nature of deaths that have resulted in the development of recommendations, the types of recommendations that have been made, and the nature of the responses/outcomes of each of these recommendations.

Nature of Deaths

Overall, the majority of child deaths investigated by the BC Coroners Service for which recommendations were made in 2002 were classified as Accident. In fact, 6 of the 12 of such deaths were classified as Accident, while three were classified as Suicide, two were classified as Natural, and one was classified as Undetermined. In order to capture the nature of the recommendation, the cases for which recommendations were made are presented below by the point at issue in the case.

Issue	Details of Death	Recommendation	Outcome(s)/Response(s)
<i>Hospital Procedures</i> <u>Case 1 of 5</u>	Death of baby born prematurely due to injury from tubal ligation surgery	Recommendation that relevant hospital conducts pregnancy tests prior to all tubal ligation surgeries	Pregnancy tests now conducted on all women prior to tubal ligations at relevant hospital
<u>Case 2 of 5</u>	- Mother fell asleep in hospital bed while breast-feeding - Infant died of suffocation under mother's breast	- Recommendation that all maternity ward physicians & nurses and prenatal care nurses of relevant hospital review case - Recommendation to consider warning parents-to-be about dangers of infant suffocation in maternal bed	- Several opportunities provided to staff and physicians to review case - Quality improvement team formed to implement open visiting policy for support person on postpartum unit and to ensure smooth transition from postpartum beds to private rooms - Educational materials developed to communicate change in policy & evaluation survey developed for families - Postpartum teaching reviewed
<u>Case 3 of 5</u>	Death of premature baby	Recommendation to send Judgment of Inquiry to	Judgement sent; No response required

	in hospital - cardio-respiratory failure due to sepsis	relevant hospital for educational and informational purposes	
<u>Case 4 of 5</u>	- Death of child from cardiac arrhythmia due to an underlying compromised myocardium - Issues surrounding fluid documentation	- Recommendation that Judgement of Inquiry be sent to relevant hospital for informational and educational purposes - Emphasis on the importance of complete and accurate documentation of fluid intake and output of patients	Judgment sent; No response required
<u>Case 5 of 5</u>	- Death of a child following reconstructive jaw surgery - Issues surrounding post-operative oxygen saturation monitoring	Recommendation that continued oxygen saturation monitoring might be considered on all post-operative patients at relevant hospital until the ability to maintain satisfactory saturations on room air has been demonstrated	Judgement sent; Response not yet received
<i>Ambulance Response Times</i> <u>Case 1 of 1</u>	- Child Suicide with weapon - Ambulance dispatcher concerned with safety of scene for their staff	Recommendation that BCAS review 'wait policy' when responding to scenes of perceived violence, and that BCAS review its compliance relative to call evaluation, pre-arrival instructions, and response to the public's request for service	- Ambulance policies have been reviewed and deemed appropriate as is - Police ability to provide back-up coverage has been enhanced & case has been reviewed and used as a teaching tool in training dispatchers to help prevent future delays
<i>Boating Incident</i> <u>Case 1 of 1</u>	Death of child passenger in personal watercraft between handlebars and operator	- Recommendation regarding positioning of passengers on personal watercraft so that no passenger is seated in front of operator - Recommendation that prohibition of children from riding on personal watercraft until they reach an age and size where they can be safely seated behind the operator	- Canadian Coastguard issued an advisory that no child under the age of six should be a passenger on these watercraft - Amendments also made to Office of Boating Safety website and the Safe Boating Guide to include section dealing with particular precautions that should be taken with respect to children on pleasure craft
<i>Construction Site</i> <u>Case 1 of 1</u>	Death of child playing around dump truck on construction site	Recommendation made to construction company to warn residents of potential dangers, and to Mayor of relevant municipality for informational purposes	Policy adopted by construction company to distribute notices to residents and to post warning signs around site

<i>Suicide Assessments</i> <u>Case 1 of 2</u>	• Child Suicide • History of suicidal ideation and attempts, and of psychiatric assessments	• Recommendation to forward Judgement of Inquiry to relevant health authority for review and for educational purposes	• Judgement sent; No response required
<u>Case 2 of 2</u>	• Child Suicide • Had previous contact with school counselors with little follow-up/referral	• Recommendation to review available counseling services at the relevant high school, to review the minimum standards of qualification, ongoing training and certification to counselors, and to review the development and implementation of policies and procedures for the assessment and management of at risk students • Recommendation to Canadian Counseling Association in support of provincial standards for all counselors and counseling services	• School has undergone major review of its policies and procedures for assessing and managing potentially at risk students, resulting in a new guide for school counselors • Counselors in relevant district upgraded their qualifications to ensure that all counselors who work with at risk students have appropriate training • Further external review of district training, protocols and practices regarding suicide counseling and suicide prevention conducted
<i>Child Protection</i> <u>Case 1 of 1</u>	• Accidental child death due to fall from father's arms • Previous Ministry of Children and Families involvement	• Recommendation to send case to Ministry of Children and Families for informational purposes	• Judgement sent; No response required
<i>Motor Vehicle Safety</i> <u>Case 1 of 1</u>	• Motor vehicle child death in three car collision at intersection • Child was passenger in rear of vehicle, and was not wearing a seatbelt	• Recommendation made revolved around concerns voiced by local residents regarding the problem intersection • This recommendation was sent to the Ministry of Transportation for review of operation of the intersection and to determine whether improvements are necessary	• Response indicates that staff will review the operation of the problem intersection to determine whether improvements are necessary

Part 4 - What the Other Provinces Are Doing

A general overview of all the Child Death Review process in all of the provinces and territories reveals that there exists *no universal standard process* for Child Death Review in Canada. These jurisdictions vary in many respects, including the nature of the committees that review child deaths, if indeed such a committee exists, as well as in the duties performed by these committees. Below is a brief description of the process in each of the provinces/territories that provided our office with a description of their current Child Death Review process.

Alberta	• Paediatric Death Review Committee- a multidisciplinary committee • Facilitates agency communication • Facilitates information sharing • Aids in the identification of systemic problems • Has no mandate to develop, distribute, or enforce recommendations
Manitoba	• Children's Inquest Review Committee (CIRC)- a multidisciplinary, ad hoc committee that reviews all aspects surrounding the deaths of children • Is responsible for reviewing all unnatural child deaths and natural deaths referred by the Chief Medical Examiner (CME) • CIRC includes a medical subcommittee that reviews all child deaths due to natural causes • Separate from the CIRC, the CME conducts a review of child welfare services where the child or his/her parents/guardians received service in the previous year, focusing on the quality of service and whether service met provincial statutes, regulations and standards
Ontario	• Paediatric Death Review Committee- a multidisciplinary committee • Determines the manner and cause of child deaths • Promotes prevention through education, protocol development and dissemination of information to relevant stakeholders
Quebec	• Two experimental committees • These committees review all child deaths that appear suspect • They have no legislative mandate • 2001 protocol developed by Coroners Office and police requiring that police investigate all deaths of children aged 5 years and younger
Yukon	• Due to low number of child deaths, there is no Child Death Review committee or protocol in the Yukon
Northwest Territories	• NWT Child and Youth Fatality Review Committee- a multidisciplinary committee • While chaired by the Coroners Service, this committee reviews <i>all</i> child and youth deaths • Provides recommendations • Supports recommendations already made by Coroners Service regarding deaths investigated by the Service

Conclusion

Our ability as an agency to address the preventative portion of our mandate depends largely on our ability to investigate common causes of death. We are continuing to improve uniform reporting and collection of data and developing investigative protocols. The agency's continued emphasis on research and statistical analysis will contribute to our ability to fulfill this mandate, as will the development of a broad-based database, which is currently underway. More specifically, these two factors will allow for the examination of issues in the aggregate.

As this report on child deaths is the first of its kind to be produced by the BC Coroners Service, it has primarily descriptive qualities. In future years, this aggregate, macro-level focus that we as an agency are moving toward will facilitate longitudinal and comparative research, ultimately enhancing our prevention capabilities.



BC CORONERS SERVICE Child and Youth Deaths - 1999 to 2003

Ministry of Public Safety and Solicitor General
Policing and Community Safety Branch

Office of the Chief Coroner of British Columbia
Metrotower II, Suite 2035
4720 Kingsway Avenue
Burnaby, BC V5H 4N2

Telephone: 604 660-7745
Facsimile: 604 660-7756
Website: <http://www.pssg.gov.bc.ca/coroners/index.htm>

	2003	2002	2001	2000	1999
0 years old	65	59	48	54	76
1 year old	13	6	13	9	13
2 years old	9	6	4	2	3
3 years old	3	3	5	5	10
4 years old	5	5	1	3	3
5 years old	5	3	5	3	5
6 years old	6	1	2	1	1
7 years old	5	6	6	4	5
8 years old	3	2	4	2	2
9 years old	5	6	3	2	3
10 years old	5	4	1	3	6
11 years old	1	6	6	5	5
12 years old	4	8	4	4	5
13 years old	8	8	4	4	4
14 years old	9	11	9	9	15
15 years old	17	13	8	19	19
16 years old	14	19	18	27	20
17 years old	29	22	25	32	28
18 years old	28	23	27	38	29
TOTAL	228	211	193	226	252

	2003	2002	2001	2000	1999
ACCIDENT	101	88	95	100	109
HOMICIDE	8	13	5	14	10
NATURAL	34	30	40	39	55
NON-CORONERS	33	29	27	36	46
SUICIDE	18	24	11	30	22
UNDETERMINED	34	27	15	7	10
TOTAL	228	211	193	226	252

	2003	2002	2001	2000	1999
Female	89	72	76	87	95
Male	135	139	118	138	155
Unknown	4	0	1	0	2
TOTAL	228	211	193	226	252

	2003	2002	2001	2000	1999
January	17	22	19	24	21
February	16	19	14	14	14
March	22	28	15	22	23
April	22	12	16	9	12
May	22	18	15	23	30
June	26	17	14	25	20
July	24	15	19	24	32
August	18	26	20	23	28
September	18	11	18	11	23
October	15	16	11	18	20
November	17	15	12	11	14
December	11	12	20	22	15
TOTAL	228	211	193	226	252

	2003	2002	2001	2000	1999
School/University	0	1	1	0	0
Construction Site: Commercial	0	0	0	1	0
Industrial	0	0	1	0	0
Industrial - Material Hand.	1	0	0	0	0
Other Place of Work	0	0	0	1	0
TOTAL	1	1	2	2	0

	2003	2002	2001	2000	1999
Substance					
Alcohol	1	0	0	0	0
Alcohol/Drug	0	0	0	1	0
Drugs: Not	1	3	4	2	2
Drugs: Non-RX	0	1	0	0	0
Drugs: RX	1	0	3	3	1
TOTAL	3	4	7	6	3

	2003	2002	2001	2000	1999
Recreational Activity					
LAND					
Hiking/Climbing	2	2	0	1	0
In-line Skating ('00)	1	0	1	1	0
Mountain Biking ('99)	1	0	0	0	0

NOTE: The BC Coroners Service works in a real-time database environment and therefore statistics are subject to slight changes until coroners' investigations are complete.

Skateboarding	1	1	0	0	0
Street Bike (No MVA)	0	0	0	1	0
Team Sports	0	1	1	2	0

MOTORIZED

Dunebuggy	0	1	0	0	0
Motorbike/ATV/Offroad	2	0	4	1	2
Personal Water Craft	1	1	0	0	0
Power Boating	1	0	2	3	1

OTHER

Public Park	0	1	0	0	3
Recreation Centre	0	1	0	0	0
Recreation other	1	1	1	4	3
Ultra-light Aircraft	0	0	0	0	1

SNOW

Snowboarding	0	1	0	2	1
Snowmobiling	0	0	0	0	2
Snowskiing	7	1	1	0	0

WATER

Canoe	1	0	3	0	0
Diving	0	0	1	2	0
Fishing	0	2	0	1	2
Innertube	0	0	0	0	1
Rowboat	0	1	0	0	0
Swimming **	4	5	3	3	6

TOTAL	22	19	17	21	22
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	2003	2002	2001	2000	1999
FRASER	52	57	68	64	69
INTERIOR	52	42	43	46	68
ISLAND	42	47	36	44	45
METRO	36	40	25	30	26
NORTH	36	25	21	42	44
TOTAL	228	211	193	226	252

	2003	2002	2001	2000	1999
12 years	1	2	0	0	0
13 years	0	2	0	1	0
14 years	1	4	2	4	2
15 years	4	4	0	6	3
16 years	1	3	3	4	6
17 years	4	3	4	6	7
18 years	7	6	2	9	4
TOTAL	18	24	11	30	22

	2003	2002	2001	2000	1999
ALCOHOL / DRUG / OTHER PO	0	0	2	2	1

CARBON MONOXIDE POISONI	0	0	0	1	0
DROWNING	1	0	1	2	0
FALL	2	2	2	2	0
FIREARMS	2	2	1	5	6
HANGING	12	16	3	17	15
MOTOR VEHICLE INVOLVED	0	2	0	0	0
OTHER	1	1	2	1	0
STABBING OR INCISED INJUR	0	1	0	0	0
TOTAL	18	24	11	30	22

	2003	2002	2001	2000	1999
100 Mile House	0	0	0	2	0
108 Mile Ranch	0	0	1	0	0
150 Mile House	0	0	0	0	2
70 Mile House	0	0	0	0	1
Abbotsford	6	7	6	10	8
Agassiz	0	1	2	0	2
Ahousaht	0	0	1	0	0
Aldergrove	0	0	0	1	1
Alert Bay	0	0	0	0	1
Alexis Creek	0	0	0	2	2
Anmore	0	1	0	0	0
Armstrong	0	1	0	0	3
Ashcroft	0	0	0	1	0
Atlin	0	0	0	0	1
Barriere	1	1	0	1	0
Beaverdell	0	0	0	0	1
Belcarra	1	0	0	0	0
Bella Bella	0	0	0	1	1
Bella Coola	1	1	1	1	0
Big Creek	0	0	0	0	1
Black Creek	0	0	0	1	2
Blind Bay	1	0	0	0	0
Blue River	1	0	0	0	0
Bonapart Reserve	0	0	0	0	1
Boston Bar	0	1	4	0	0
Bowen Island	0	0	0	1	0
Brentwood Bay	0	0	0	0	1
Brisco	0	0	0	1	0
Buffalo Creek	1	0	0	0	0
Burnaby	5	2	7	6	8
Burns Lake	0	1	0	2	2
Cache Creek	2	1	0	0	0
Calgary	0	0	0	0	1
Campbell River	2	3	1	1	1
Canyon	0	0	1	0	0
Castlegar	1	1	0	1	2
Celista	1	0	0	0	2
Charlie Lake	0	0	0	1	0
Chase	1	2	0	0	0
Cherry Creek	0	1	0	0	0
Chetwynd	0	1	0	0	1
Chilliwack	12	2	7	3	6

NOTE: The BC Coroners Service works in a real-time database environment and therefore statistics are subject to slight changes until coroners' investigations are complete.

Clearwater	0	1	0	1	1	Lumby	0	0	1	0	2
Coal Harbour	0	0	0	1	0	Lytton	0	0	1	0	0
Cobble Hill	0	2	1	0	1	Mackenzie	0	0	0	0	1
Comox	3	0	1	0	2	Manning Park	1	0	0	0	0
Coquitlam	1	3	1	5	4	Manson Creek	0	0	0	0	1
Courtenay	0	2	3	1	2	Maple Ridge	3	1	3	2	4
Cranbrook	1	0	1	3	1	Massett	1	0	0	1	0
Crescent Valley	0	0	0	2	0	McBride	0	1	0	0	0
Creston	2	0	1	0	1	Merritt	0	2	1	2	5
Crofton	0	1	0	0	0	Mill Bay	0	1	0	0	0
Dawson Creek	1	2	1	3	1	Mission	1	4	4	1	1
Delta	6	5	4	4	2	Montrose	0	0	0	0	1
Denman Island	0	0	0	0	1	Morisetown	0	0	1	0	0
Deroche	1	1	0	1	0	Mount Currie	0	1	0	0	0
Duncan	5	0	2	5	4	Nakusp	0	0	0	1	0
Elkford	1	0	0	0	0	Nanaimo	12	10	3	5	3
Enderby	0	0	0	0	1	Nanoose Bay	0	0	1	1	0
Errington	0	0	0	0	1	Naramata	0	1	0	0	0
Fairmont Hot Springs	1	0	0	0	2	Nelson	0	0	1	2	0
Falkland	1	0	2	1	0	New Aiyansh	0	0	0	1	0
Fernie	0	1	0	0	0	New Denver	0	1	0	0	0
Forest Grove	0	0	1	0	0	New Hazelton	0	0	2	0	0
Fort Nelson	1	0	2	2	0	New Westminster	0	3	1	1	4
Fort St James	1	1	1	1	1	Nitnaht	0	0	0	1	0
Fort St John	1	2	2	5	1	North Vancouver	4	5	3	4	4
Fort Ware (Kwadacha)	1	0	0	0	0	Not Specified	0	0	1	0	0
Fraser Lake	2	0	0	0	0	Oliver	0	0	0	3	1
Gilford Island	0	0	0	1	0	Osoyoos	0	0	1	0	1
Golden	1	1	1	2	0	Oyama	0	1	0	0	0
Grand Forks	2	0	1	0	2	Parksville	0	1	1	1	2
Hagensborg	0	0	1	0	0	Pemberton	0	0	0	1	0
Hanceville	0	0	1	0	0	Pender Harbour	1	0	0	0	0
Hazelton	1	0	0	1	2	Pender Island	0	1	0	0	0
Heffley Creek	0	0	1	0	0	Penticton	1	3	1	2	2
Hendrix Lake	2	0	0	0	0	Pinantan Lake	0	1	0	0	0
Hope	2	2	2	1	0	Pink Mountain	0	0	0	0	1
Houston	1	1	0	1	0	Pitt Meadows	2	0	0	1	1
Invermere	1	1	1	0	1	Port Alberni	2	2	1	3	2
Jaffray	0	0	0	0	1	Port Coquitlam	3	2	1	0	1
Kamloops	4	8	7	4	8	Port Hardy	0	1	1	2	3
Kaslo	0	0	0	0	1	Port McNeill	1	0	0	0	0
Kelowna	4	3	5	4	5	Port Moody	1	2	0	1	0
Keremeos	0	0	2	3	1	Port Renfrew	0	0	0	0	1
Kimberley	1	0	0	0	0	Port Simpson	0	0	0	1	1
Kitimat	2	2	0	0	0	Pouce Coupe	3	0	0	0	0
Kuper Island	0	1	0	0	0	Powell River	0	2	1	1	0
Kyuquot	0	1	0	0	0	Prince George	7	4	4	7	11
Ladysmith	1	2	0	0	1	Prince Rupert	2	1	1	4	2
Lake Country	0	0	0	0	1	Princeton	0	2	0	0	1
Lake Cowichan	1	0	0	2	0	Pritchard	0	0	0	0	1
Langley	3	7	5	3	7	Qualicum Beach	0	1	1	1	0
Lillooet	0	0	0	1	0	Quatsino	1	6	0	0	0
Lister	0	0	0	1	0	Quesnel	2	2	0	2	4
Little Fort	0	0	0	0	1	Radium Hot Springs	2	0	0	0	0
Lone Butte	0	0	0	1	0	Revelstoke	7	0	3	0	0
Lower Nicola	0	0	2	0	0	Richmond	2	6	5	5	3
Lower Post	0	0	0	0	1	Ridge Meadows	0	0	0	0	1

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Reffa	0	0	0	0	1
Rossland	0	0	1	0	0
Royston	0	0	1	0	0
Salmo	0	1	1	1	0
Salmon Arm	2	0	1	2	0
Saltspring Island	1	1	0	1	0
Sandspit	0	0	0	1	0
Savona	1	0	0	1	0
Sechelt	0	1	0	0	0
Shawnigan Lake	0	0	0	1	0
Shoreacres	0	0	1	0	0
Sidney	2	0	1	2	0
Silverton	0	0	0	0	1
Slocan	0	0	0	0	1
Smithers	0	1	1	0	1
Sooke	0	0	0	0	1
South Slocan	0	0	0	0	1
Sparwood	1	0	0	0	1
Squamish	1	2	2	0	0
Stewart	1	0	0	1	0
Summerland	2	2	0	0	1
Surrey	18	14	13	19	14
Takla Landing	0	0	0	1	0
Terrace	5	4	0	2	3
Thrus	0	0	0	1	0
Tofino	0	1	0	1	0
Trail	0	3	0	0	0
Tsay Keh Dene	0	0	0	1	0
Ucluelet	0	0	1	0	0
Valemount	0	1	0	1	1
Van Anda	0	0	1	0	0
Vancouver	22	20	22	22	22
Vanderhoof	0	1	0	2	0
Vernon	2	1	3	1	7
Victoria	10	7	12	8	14
Watson Lake	0	0	0	0	1
West Vancouver	1	2	0	3	1
Westbank	0	1	0	0	1
Whistler	0	0	2	0	0
White Rock	0	0	1	0	1
Whitehorse	0	1	0	0	0
Williams Lake	4	1	2	0	2
Wilmer	1	0	0	0	0
Windermere	2	0	0	0	0
Winfield	1	1	0	1	1
Winlaw	0	0	0	0	1
Yale	1	0	0	0	0
Yubou	0	0	0	0	1
TOTAL	228	211	193	226	252

COMMERCIAL TRUCK PASSENGER	0	0	0	0	1
PEDESTRIAN	5	7	5	8	7
MOTORCYCLE / MOPEL	2	1	1	2	1
PEDAL CYCLIST	1	1	0	1	4
OTHER	1	1	1	1	2
ATV / DIRT BIKE	2	1	5	2	1
TOTAL	64	48	45	62	72

Position of Decedent	2003	2002	2001	2000	1999
DRIVER	13	10	9	17	20
PASSENGER	40	27	25	31	36

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Questions related to this report should be directed to:

E-Mail: BC.CorSer@gems7.gov.bc.ca

Telephone: 604 688-7745

Facsimile: 604 660-7766

Post: Office of the Chief Coroner of BC

Research and Statistics

Metrotower II, Suite 2035

4720 Kingsway Avenue

Burnaby, BC V5H 4N2

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